



Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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Third District

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Fourth District

Michael D. Antonovich
Fifth District

Bruce A. Chernof, MD
Director and Chief Medical Officer

John R. Cochran III
Chief Deputy Director

Robert G. Splawn, MD
Senior Medical Director

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

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*To improve health
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June 15, 2007

TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.
Director and Chief Medical Officer

SUBJECT: **PLAN OF CORRECTION DATED 5/18/07**

This is to provide you with a copy of the Plan of Correction without the supporting attachments we will be submitting to the Centers for Medicare and Medicaid Services (CMS) on 6/15/07. This plan identified deficiencies under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) which governs the care of patients presenting to emergency rooms. There were three principle findings and some supplemental findings.

The first citation centered on the posting of signs notifying patients that they are entitled to a medical screening exam and treatment. Although the legally required, bilingual signs were posted in the Emergency Room waiting areas at the time of the survey, the surveyors requested that additional signs be posted in the Emergency Room treatment area. These additional signs have been posted.

The second citation involved the failure to record one patient on a required central log that records all patients who come into the emergency room. This one patient, as we now know, was inappropriately ignored by the triage nurse. Had this patient been appropriately triaged at this visit, the central log would have been completed. This is a failure of one individual and that individual is no longer with the County. There was a supplemental finding related to time differences noted between the initial manual sign-in log and the automated log that becomes the ER record. This problem was corrected by changing the computer screens to require the registration staff to verify the times against the log prior to final entry. Audits will be done on a daily basis to verify compliance.

The third citation is the failure to provide a medical screening exam for this one patient as required under the EMTALA regulations. Because the triage nurse ignored this patient, she did not receive a triage exam, she did not get entered into the central log and she did not, then, receive a medical screening exam. The surveyors reviewed 27 patient records and found only this one EMTALA issue in this summary.

Each Supervisor
June 15, 2007
Page 2

A comprehensive investigation was completed shortly after this event. Within 2 days of this event, the triage nurse was placed on administrative leave and interviews were conducted and a thorough investigation was performed. Corrective actions for all staff in the ED, including non-clinical staff such as Environmental Services workers, Safety Police and Patient Financial Workers were completed to ensure that all staff understand and are aware of their obligations for patients. Two CNA's, one LVN, three registration staff and one Environmental Services staff received official "letters of expectation" documenting the actions they are required to take on behalf of patients and the requirement to escalate concerns regarding patients to the proper higher level. The entire Emergency Department staff received specific training on EMTALA, the regulation requiring a Medical Screening Exam and additional training regarding their roles in dealing with patients in emergency situations and compliance with hospital policies. The Office of Public Safety Officers have received training in their responsibilities under EMTALA.

We fully expect to be found in complete compliance with this plan of correction. We have internally validated the actions taken and do not anticipate any further actions required from this survey. CMS will likely revisit the facility within the next 30 days to validate the corrective actions. As you know, CMS also has requested an additional Plan of Correction related to the neurosurgery transfer delay case and that POC will be completed Monday.

If you have any questions or need additional information, please let me know.

BAC:ls

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors



MARTIN LUTHER KING, JR.
HARBOR HOSPITAL

June 15, 2007

VIA FACSIMILE and OVERNIGHT MAIL

Los Angeles County
Board of Supervisors

Glória Molina
First District

Yvonne B. Burke
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Antionette Smith Epps
Administrator

Roger A. Peeks, MD
Chief Medical Officer

Dellone Pascascio, RN
Chief Nursing Officer

12021 S. Wilmington Avenue
Los Angeles, CA 90059

Tel: (310) 658-5201
Fax: (310) 638-8193

*To provide compassionate, high
quality care that improves the
health status of our patients,
their families and the
communities we serve without
regard to ability to pay*

Michelle Griffin, Branch Manager
Hospital and Community Care Operations
Division of Survey and Certification
Centers for Medicare and Medicaid Services
90 7th Street, Suite 5-300(5W)
San Francisco, CA 94103-6707

Dear Ms. Griffin:

**PRELIMINARY DETERMINATION LETTER FOR MARTIN LUTHER KING, JR. -
HARBOR HOSPITAL**

Enclosed for your consideration is the Plan of Correction prepared by Martin Luther King Jr.-Harbor Hospital ("MLK-Harbor"), Provider No. 05-0578, in response to the Centers for Medicare and Medicaid Services' ("CMS") notice of preliminary determination to terminate MLK-Harbor's Medicare participation dated June 5, 2007, and received by the hospital on June 7, 2007. Also enclosed are a series of attachments containing documents, which substantiate the various corrective actions discussed in the Plan of Correction. It is our belief that this rigorous Plan of Correction contains credible evidence that the circumstances which lead CMS to conclude that MLK-Harbor was out of compliance with the terms of its Medicare Provider Agreement have been remediated, and that there is a compelling basis for the planned termination action to be rescinded.

We welcome this opportunity to evaluate MLK-Harbor's systems, both to better serve our patients and to ensure continued compliance with EMTALA's requirements. As you are aware, the incident prompting the investigation which led to the preliminary decision to terminate MLK-Harbor's Provider Agreement was reported by MLK-Harbor itself to CMS and California's Division of Licensing shortly after the incident occurred. Recognizing the problematic nature of the situation, the hospital promptly suspended the triage nurse who had been on duty and conducted an immediate and thorough internal investigation. As a result, and as described in more detail in the enclosed Plan of Correction, MLK-Harbor took the following actions:

- All emergency department staff received focused training less than a week after the incident occurred to assure there would be no recurrence, and a monitoring plan has been put into place to assure that any future lapses are either prevented outright, or are detected and corrected before any patient harm can occur.
- Training and monitoring of staff from the Office of Public Safety has occurred to assure that they understand how the requirements of EMTALA constrain their behavior.
- Without conceding that the signage in the emergency department was inadequate, MLK-Harbor has increased the number of places that signs, outlining the hospital's obligations under EMTALA and announcing its participation in Medicaid, are now found.
- MLK-Harbor has identified and corrected systems issues which helped to produce the discrepancies in the ER logs which were cited by the surveyors.



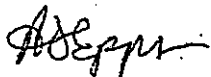
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Michelle Griffin
June 15, 2007
Page 2

Based on these corrective actions, and those additional actions detailed in the attached materials, MLK-Harbor believes that it has taken sufficient steps to assure that the deficiencies cited as the basis for CMS' termination decision are corrected and will not reoccur, and that the preliminary decision to terminate MLK-Harbor's participation in Medicare may be rescinded.

If you have any questions about the forgoing, please do not hesitate to contact me.

Sincerely,



Antionette Smith Epps
Administrator

ASE:es

c: Jackie Lincer
Bruce A. Chernof, MD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050578	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05118/2007
		B. WING		

NAME OF PROVIDER OR SUPPLIER

LAC/MARTIN LUTHER KING JR GEN HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS The following reflects the findings of the Department of Health Services during the investigation of an EMTALA COMPLAINT NO CA001 14549. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Health Services: Barbara Mellor, HFEN, Raul Reyes, HFEN, Sanford Weinstein, Medical Consultant.	A 000		
A 400	489.20(r) COMPLIANCE WITH §489.24 The provider agrees, in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on interviews, review of 30 closed medical records, review of an incident report, review of selected policies and procedures from the hospital, review of a surveillance video and review of selected human resource files, the hospital failed to comply with the provisions of 42CFR 489.24 when it failed to provide a medical screening examination and necessary stabilizing treatment for each patient presenting for evaluation of an emergency medical condition. Findings The facility failed to comply with the provisions of 42CFR 489.24(q), A402, when it failed to post signage conspicuously in the treatment area of the emergency room, likely to be noticed by all individuals. The facility failed to comply with the provisions of 42CFR 489.20(r)(3), when it failed to enter Patient #1 into the central log of the computer, A405 The facility failed to comply with	A 400	Survey Findings: Failure to post signage conspicuously in the treatment area of the emergency room. Permanent Action: Additional signs were posted specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor in four treatment areas, three in the ED treatment area and one in dental clinic - unit 4L in places likely to be noticed by all individuals entering the Emergency Department. Signs were also placed in the Urgent Care waiting room and in the Peds Urgent Care waiting room. These signs identify the individual's right to examination and treatment for emergency medical conditions and women in labor and identify this hospital as a participant in the Medicaid program. A copy of the signage is attached - Attachment #1. Monitoring: During Environment of Care (EOC) rounds, the Facilities Manager shall visually verify the presence of each of the signs in the Emergency Room treatment areas, the Urgent Care, and Peds Urgent Care and document these findings in the environmental tour report. Findings from the EOC rounds are reported quarterly to the QI committee. This item has been added to the EOC rounds form. See Attachment #2 EOC Rounds Form. Person Responsible: Facilities Manager	5/14/07

(Continued on Page 1A)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 050578	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05118/2007
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NAME OF PROVIDER OR SUPPLIER LAC/MARTIN LUTHER KING JR GEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, CA 90059
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER

LAC/MARTIN LUTHER KING JR GEN HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

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LATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

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LOS ANGELES, CA 90059

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ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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			Continued on Page 1D	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVAL
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER-CLIA IDENTIFICATION NUMBER: 050578	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/18/2007
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NAME OF PROVIDER OR SUPPLIER AC/MARTIN LUTHER KING JR GEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, GA 90059
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A 400	Continued From page 1 the provisions of 42CFR 489.24(x) when it failed to provide a medical screening examination for Patient #1, A406. The cumulative effect of these systemic practices limited the hospitals ability to provide safe patient care.	A 400		
A 402	489.20(q) POSTING OF SIGNS The provider agrees, in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX. This STANDARD is not met as evidenced by: Based on observation and staff interview the hospital failed to post signage in the treatment areas of the emergency regarding an individual's right to examination and treatment for emergency conditions and women in labor. In addition, there was no sign posted in the treatment area identifying if the hospital participated in the Medicaid program. Findings: A tour of the emergency room treatment areas was conducted at 1500 hours on 5/17/07. There	A 402	Permanent Action: Additional signs were posted specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor in four treatment areas, three in the ED treatment area and one in dental clinic – unit 4L in places likely to be noticed by all individuals entering the Emergency Department. Signs were also placed in the Urgent Care waiting room and in the Peds Urgent Care waiting room. These signs identify the individual's right to examination and treatment for emergency medical conditions and women in labor and identify this hospital as a participant in the Medicaid program. A copy of the signage is attached. (Attachment #1) Monitoring: During Environment of Care (EOC) rounds, the Facilities Manager shall visually verify the presence of each of the signs in the Emergency Room treatment areas, the Urgent Care, and Peds Urgent Care waiting areas and document these findings in the environmental tour report. Findings from the EOC rounds are reported quarterly to the QI committee. This item has been added to the EOC rounds form. See Attachment #2 EOC Rounds Form. Person Responsible: Facilities Manager	5/14/07

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FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050578	A. BUILDING		C 0511812007
		B. WING	-	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACI;VIAI TIN LUTHER KING JR GEN HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 402	Continued From page 2	A 402		
A 405	<p>were no signs posted regarding the right to a medical screening exam or if the hospital participated in the Medicaid program. The manager of the emergency room stated there were no signs posted in the treatment areas.</p> <p>489.20(r)(3) ER LOG</p> <p>The provider agrees, in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(h), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.</p> <p>The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services.</p> <p>This STANDARD is not met as evidenced by: Based on a review of medical records, emergency room logs, hospital documents and a surveillance camera tape, the hospital failed to ensure seven of 27 sampled patients seeking assistance from the emergency room was promptly and accurately entered into a central log. (Patient #1, #13, #18, #20, #23, #24, and #25).</p> <p>Findings</p> <p>1. At 1600 hours on 5/17/07 an incident report from the Office of Public Safety was reviewed. It indicated that at approximately 0034 hours on 5/9/07 Patient #1 was seen by safety officers on the grounds of the hospital. She stated that her</p>	A 405	<p>Surveyors Findings:</p> <p>Seven of 27 patients seeking assistance from the emergency room were not promptly and accurately entered into a central log.</p> <p>Immediate Actions:</p> <p>Patient #1:</p> <ul style="list-style-type: none"> Facility investigation determined that the registered nurse assigned to triage failed to enter this patient into the central log. This registered nurse was placed an administrative leave on 5/11/07 and resigned on 5/16/07. On 5/16/07, the registered nurse was reported to the California Nursing Board (Attachment #III). <p>Patients #13, 18, 20, 23, 24 and 25:</p> <p>Facility investigation determined that when patients presented to the ED, the registered nurse evaluated the patient initially and completed the flow sheet. After this evaluation, the patient was seen by registration. The electronic ED log defaults to the time of entry by the registration staff which lead to the discrepancies noted by the survey. A multidisciplinary group reviewed and revised emergency registration/admitting policy #1.1.32 entitled Registration and Financial Screening to require original time of arrival entered into the computerized central log to be congruent with the nursing flow sheet.</p> <p>The screen was modified to require the registration clerk to validate the date and time. See Attachment #VI - Computer Screen Example.</p>	5/16/07
				6/13/07

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NAME OF PROVIDER OR SUPPLIER AC/MARTIN LUTHER KING JR GEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, CA 90059
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A 405	<p>Continued From page 3</p> <p>stomach hurt. A short time later, she was taken by hospital staff to the registration window of the emergency room with the safety officers following. A surveillance camera tape of the emergency room for 519107 showed Patient #1 first presented to the emergency room treatment (triage) window at 0101 hours. The emergency room (ER) log did not reflect her original arrival time or the nature of her complaint. Instead, the log listed that she arrived at the emergency room at 0200 hours in full cardiac arrest.</p> <p>The medical record for Patient #1 shows she had several emergency room visits in April and May 2007. The Emergency Nursing Flow Sheet dated 517/07 documented the patient arrived at 2315 hours. The ER log did not include this entry. Instead an entry was made that the patient</p> <p>arrived at the ER at 0415 hours on 5/8/07.</p> <p>2. The Emergency Nursing Flow Sheet for Patient #18 documented that he arrived in the ER at 1530 hours on 11/1/07. The ER log lists the patient as arriving 12 hours later at 0330 hours on 11/2/07 hours.</p> <p>3. The Emergency Nursing Flow Sheet for Patient #13, documented that he arrived in the ER at 1235 hours on 5/14/07. The ER log lists the patient as arriving 1 hour later at 1313 hours.</p> <p>4. The Emergency Nursing Flow Sheet in the medical record for Patient #24, documented he</p> <p>arrived at the ER at 2320 hours on 5/18/07. The ER log shows his arrival time as 0007 hours on 5/19/07.</p> <p>5 The Emergency Nursing Flow Sheet for Patient #20, documented that she arrived in the</p>	A 405	<p>Monitoring: Ten charts will be randomly reviewed each day to validate that the time recorded on the central log and the nursing flow sheet is consistent and accurate. Results of the chart review will be reported weekly on the weekly dashboard. The dashboard is presented to Quality Performance Improvement Committee monthly and to Quality Council/Medical Executive Committee quarterly.</p> <p>Responsible Position: HIM Director</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR
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STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050578	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 0511812007
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STREET ADDRESS, CITY, STATE, ZIP CODE

ACIMART1N LUTHER KING JR GEN HOSPITAL

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

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A 405	Continued From page 4 ER at 0107 hours on 112/07. The ER log lists the patient as arriving at 0121 hours. 6. The Emergency Nursing Flow Sheet in the medical record for Patient 25 documented that he arrived in the ER at 0350 hours on 11124106. The ER log lists the patient as arriving at 0406 hours. 7. The Emergency Nursing Flow Sheet for Patient #23 shows she arrived in the ER at 1355 hours on 1219106. The ER log lists the patient as arriving at 1424 hours.	A 405		
A 406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction. If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the	A 406		

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NAME OF PROVIDER OR SUPPLIER ACIMARTIN LUTHER KING JR GEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, CA 90059
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A 406	<p>Continued From page 5</p> <p>hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.</p> <p>Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.</p> <p>If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.</p> <p>This STANDARD is not met as evidenced by: Based on administrative staff interview, medical record and policy and procedure (P&P) review, and a review of nurse staffing, an incident report and a surveillance tape, the hospital failed to ensure one of 27 sampled patients presenting to the emergency room had a medical screening examination (Patient #1). Findings:</p> <p>At 1500 hours on 5/14/07, the hospital's triage P&Ps for the emergency room (ER) and the medical record for Patient #1 were reviewed. The triage P&P identified that two triage nurses were to be assigned in the ER. The patient's initial contact in the ER would be with a registered nurse. The nurse was to document the patient's</p>	A 406		

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NAME OF PROVIDER OR SUPPLIER ACIMARTIN LUTHER KING JR GEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 5 WILMINGTON AVE LOS ANGELES, CA 90059
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A 406	<p>Continued From page 6</p> <p>name, age and chief complaint during a "cursory assessment," of the patient prior to proceeding to the second nurse who would do the triage. The Clinical Nursing Director II stated the nurse also documents on the Emergency Nursing Flow Sheet, the date and time of arrival, age and sex of the patient, where the patient came in from, how they arrived, who accompanied them and who gave the information for the patient. The Clinical Nursing Director II stated Patient #1 was in the emergency room in the early morning hours of 5/9/07. The nurse at the ER window "eyeballed"</p> <p>the patient. The review of nurse staffing showed the ER did not have two nurses assigned to triage patients during the early morning hours of 5/9/07. In addition, the staffing sheets show that 13.58 licensed nurses were needed to care for the 39 patients already receiving treatment in the ER. There were only 11 nurses working, including the triage nurse.</p> <p>A hospital surveillance tape and incident report reviewed on 5/18/07 showed Patient #1 originally presented to the staff at the ER triage window with pain in her stomach at 0101 hours on 5/9/07. The incident report documented that the nurse told the police officers accompanying the patient, "Thanks a lot officers, she's a regular here, this is her third time here. She has already been seen and was discharged." The officers informed the nurse that Patient #1 was complaining of stomach pains. The nurse then told Patient #1 "You have already been seen and there is nothing we can do. You already have an appointment." At 0105 hours Patient #1 then slid off of the wheelchair and on to the floor on her knees in a fetal position screaming in pain. The nurse told Patient #1: "Get off the floor and on to a chair." The patient's medical record failed to include documentation of</p>	A 406	<p>Surveyor Findings: The triage policy required two registered nurses.</p> <p>The policy required two RNs:</p> <ul style="list-style-type: none"> The Chief Nursing Officer revised the triage policy to require that there be two licensed staff, one of which will always be a registered nurse, to staff ED triage. The policy requires staffing based in the patient volume. Actions are taken to meet staffing needs on a per shift basis. <p>Monitor:</p> <ul style="list-style-type: none"> The Chief Nursing Officer receives a daily report on staffing and staffing variances. Staffing levels are adjusted as needed. Staffing variance are discussed in Executive Committee. <p>Position Responsible: Chief Nursing Officer</p> <p>Surveyor Findings: The triage nurse did not assign a triage category and patient #1 did not receive a medical screening exam.</p> <p>Immediate Actions:</p> <ul style="list-style-type: none"> The triage nurse was placed on administrative leave on 5/11/07. Triage nurse resigned and was reported to the California Nursing Board on 5/16/07. On 5/17/07 continuing to 5/20/07, the ED nurse manager provided all ED staff a copy of hospital policy 317 entitled "Expedited Response to Emergency Situation Not Covered by Code Teams" and policy 316 entitled "EMTALA Compliance" (Attachment IV) and received signed acknowledgement of receipt from all ED staff. This training included the need to assure that all patients seeking medical assessment or treatment are included in the log and receive medical screening exams regardless of prior history with hospital staff on long term leave will receive EMTALA requirements training when they return. 	5/16/07 5/16/07 5/16/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR
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05/18/2007

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A 406	Continued From page 7 the cursory assessment," of Patient #1 at that time. There was no triage category assigned to the patient and she did not receive a medical screening exam to determine if she had an emergency medical condition The surveillance tape shows that for approximately 30 minutes staff members walked past the patient or worked to clean the floor next to her without interacting with her. One staff person was observed sitting behind the financial/registration window and had a view of the patient in the lobby. At 0130 hours Patient #1 was on the floor in the ER lobby kicking with her feet. Two staff members looked at the patient and then walked back through the door to an area within the ER. A male arrived at 0138 hours, checked with Patient #1 and went to the triage window and then out the side door from the ER lobby. The incident report documents the male was a friend of Patient #1. He requested help from the ER triage nurse. He then went to the police window next to the ER and asked them to help the patient because the ER staff would not. The report also documents that the friend called 911 for help but they would not respond because the patient was already at the hospital. During the time she spent in the ER lobby, Patient #1 was not triaged for her priority to be seen in the treatment area, was not provided a medical screening exam and her presence was not logged into the ER log or her medical record. The surveillance tape documents that at 0150 hours, police officers arrived and wheeled Patient #1 out of the ER lobby. At 0157 hours Patient #1 was wheeled in the chair back in the direction of the side door to the ER lobby. The medical record for Patient #1 contained an Emergency	A 406	Monitoring: Ten charts will be reviewed each week to determine whether a medical screening exam was completed. Results of this audit will be reported to the ED QI committee, then to the Quality Performance Improvement Committee and to Quality Circle/Medical Executive Committee. Positions Responsible: ED Physician Manager ED Nurse Manager Immediate Action: <ul style="list-style-type: none"> The triage nurse who failed to triage patient #1 resigned and was reported to the California Nursing Board. 5/16/07 Facility Investigation determined that several other staff in the ED area failed to acknowledge this patient or failed to escalate their concerns to higher level supervisor staff. On 5/30/07, two nursing attendants and the LVN received letters of expectation. (A letter of expectation is a letter that defines the individual's specific expectation for behavior and actions. Copy of template is provided as Attachment IV). On 5/25/07 and 5/30/07, three patient financial workers received letters of expectation. The EVS Administrator discussed expectations and chain of command with the EVS worker (a contractor). The Nurse Manager provided education on the triage policy, which includes the requirement to revise the triage designation based on changes in the patient's condition. (Attachment V) 5/03/07 The ED Nurse Manager reviewed chair of command policy with all ED staff and instructed all ED staff to comply with this policy. 5/30/07 Monitoring: <ul style="list-style-type: none"> The shift supervisor will include the ED waiting room on shift rounds each shift. The shift supervisor will randomly pick two patients in the waiting room and validate that these two patient have been appropriately and timely triaged and that the patient has been entered into the central log. In the event that discrepancies are discovered, there will be immediate corrective actions including staff retraining. 5/17/07 	

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A 406	Continued From page 8 Nursing Flow Sheet for 0200 hours On 5/9/07 when she presented to the ER in full cardiac and respiratory arrest. Attempts by ER staff to resuscitate her were unsuccessful.		<ul style="list-style-type: none">Ten entries into ED log will be reviewed each week to determine whether a medical screen exam have been completed. The results of this audit will be reported to the ED QI Committee and to Quality Performance Improvement Committee and the Quality Council/Medical Executive Committee. <p>Person Responsible: ED Nurse Manager ED Physician Director Office of Public Safety</p> <p>Surveyors Findings:</p> <p>Police officers wheeled the patient #1 out of the lobby without a medical screening exam.</p> <p>Immediate Actions</p> <ul style="list-style-type: none">On 5/17/07, the onsite Office of Public Safety (OPS) Captain briefed all sworn officers on the requirements to obtain a medical clearance for booking prior to removing a person from the health care environment. They were further instructed that if the person in question states she/he is ill and they request medical treatment, officers must see that the individual gets it.On 5/18/07 and continuing to 5/27/07, the on-site OPS captain provided inservice education to all OPS staff at MLK on EMTALA regulations and emergency response. (Attachment #IV sign-in sheets of attendance. <p>Monitoring:</p> <p>The sergeant on duty performs weekly briefings to all Office of Public Safety (OPS) personnel on EMTALA Policy #316 and Emergency Response Expectation #317. They are reviewed and discussed. After the review, the Sergeant on duty presents different scenarios to all OPS personnel. It is expected they respond with 100% accuracy. If they do not respond correctly, they are immediately corrected. Documentation of the staff's performance is kept by the sergeant.</p> <p>Position Responsible: Sergeant OPS</p>	